






CONSENT FOR TREATMENT (Commonly Used Medications)

Name _____ Date _____

I consent to treatment for my tuberculosis exposure, latent TB exposure, and/or active TB disease with the following drugs: (Check box for drug client is on)

Medications	Things That May Happen:	Comments
<input type="checkbox"/> Isoniazid (INH)	Very tired; loss of appetite; dark urine; light colored bowel movement; yellow eyes and skin; tingling hands and feet; flushing; sweating or headache after a meal.	 Caution: Avoid taking with food. Don't drink alcohol. Avoid using Tylenol (acetaminophen). No antacids within 2 hours.
<input type="checkbox"/> Rifampin (RIF) <input type="checkbox"/> Rifapentine	Very tired; loss of appetite; dark urine; light colored bowel movement; yellow eyes and skin; flu-like symptoms; heartburn; bruising. Will turn body fluids orange (tears, urine, sweat).	 Caution: Avoid taking with food. Don't drink alcohol. Birth control pills, shots, IUD, implant or ring may not work; use another method, such as condoms. May discolor soft contact lenses.
<input type="checkbox"/> Pyrazinamide (PZA)	Very tired; loss of appetite; light colored bowel movement; yellow eyes and skin; joint aches; nausea; rash.	 Caution: Don't drink alcohol. Avoid using Tylenol (acetaminophen).
<input type="checkbox"/> Ethambutol (EMB)	Difficulty seeing red and green colors, as they may look gray; vision changes; rash.	 Caution: If you notice any vision changes, tell your healthcare provider immediately.
Fluoroquinolone: <input type="checkbox"/> Moxifloxacin <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Ciprofloxacin	Nausea and bloating; headache; dizziness; pain, swelling or tearing of the tendon; muscle or joint pain; heart palpitations.	 Caution: Avoid taking within 2 hours of ingestion of milk-based products, antacids or vitamins. Call healthcare provider immediately if you experience tendon, muscle, or joint pain.

These possible side effects have been fully discussed with me by the physician and/or nurse. The benefits of this therapy have been explained to me, as well as the importance of taking the medication(s) regularly and consistently as recommended. I also understand that Directly Observed Therapy (DOT), where the nurse or an agreed upon responsible person watches me swallow my medication, is a nationally recognized standard of therapy.

I understand that most people can take the medication(s) without difficulty, but if I should develop any of the symptoms listed above, I am to contact _____ at _____ and ask to speak with a nurse. **I AM NOT TO WAIT UNTIL MY NEXT CLINIC APPOINTMENT**, but am to call right away for instructions for follow-up of my symptoms.

I have read this form or have had it explained to me. I have had an opportunity to ask my health care provider questions about my treatment and received a copy of my treatment plan. I understand the benefits and risks of taking these medications. I agree to take my Tuberculosis medications as directed.

Signature of person accepting treatment (or parent or guardian)_____
Date_____
Printed Name_____
Relationship to patient_____
Signature of Health Professional Witness_____
Date_____
Health Professional Witness (print)_____
Health Dept.